i. Face-to-face contact between the case manager and the recipient; (8-1-92)

ii. Telephone contact between the case manager and the recipient, the recipient's mental health and other service providers, a recipient's family members, primary caregivers, legal representative, or other interested persons; (8-1-92)

iii. Face-to-face contacts between the case manager and the recipient's family members, legal representative, primary caregivers, mental health providers or other service providers, or other interested persons; (8-1-92)

iv. Development, review, and revision of the recipient's individual service plan, including the case manager's functional assessment of the recipient. (8-1-92)

f. The Department will not provide Medicaid reimbursement for ongoing case management services delivered prior to the completion of the assessments and individual service plan. (8-1-92)

g. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and individual service plan. (8-1-92)

h. Audit reviews will be conducted at least once a calendar year by the Bureau. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (7-1-94)T

i. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (10-22-93)

j. The provider will provide the Department with access to all information required to review compliance with these rules. (10-22-93)

k. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (8-1-92)

l. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. (8-1-92)

i. Services may be provided during the last thirty (30) days of inpatient stay when not duplicating those included in the responsibilities of the facility, pursuant to Idaho Department of Health and Welfare, Title 03, Chapter 14, Section 200.04. (7-1-94)T

07. Record Requirements. In addition to the development and maintenance of the service plan, the following documentation must be maintained by the provider: (8-1-92)

a. Name of recipient; and (8-1-92)

b. Name of the provider agency and person providing the service; and (8-1-92)

c. Date, time, and duration of service; and (8-1-92)

d. Place of service; and (8-1-92)

e. Activity record describing the recipient and the service provided; and (8-1-92)

f. Documented review of progress toward each CM service plan goal, and assessment of the recipient's need for CM and other services at least every one hundred twenty (120) days; and (8-1-92)

g. Documentation justifying the provision of crisis assistance to the recipient; and (8-1-92)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management. (8-1-92)

117. CLOZAPINE CARE COORDINATION. (12-31-91)

01. Qualifications. The Department will make payments for care coordination services associated with prescribed Clozapine therapy to entities operating manufacturer registered Clozapine treatment systems. (2-19-92)

02. Payment Procedures. A single payment for each calendar week (or portion thereof) will be made. Payments for care coordination services are made in lieu of payments for chemotherapy visits to mental health centers and/or physician medical management services unless significant identifiable services in excess of those required by the manufacturers registered treatment system are required and documented. The rate of payment will be established in accordance with Subsection 060.04. (2-19-92)

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION. The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for adult Medicaid eligible recipients with developmental disabilities when authorized by the Department and provided by an organized service coordination provider agency who has entered into a written provider agreement/contract with the Department. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. (10-1-94)T

01. Eligible Target Group. Only Medicaid eligible adults, 21 years of age or older and eligible individuals between the ages of eighteen (18) and twenty-one (21) who have transition plans developed by the school system which identify service coordination as necessary; and desire to live, learn, or work in community based settings are eligible. All participants must have a primary diagnosis of Developmental Disability. (10-1-94)T

a. The following diagnostic and functional criteria will be applied to determine membership in the target population: (1-7-94)

i. A developmental disability is: (a) attributable to an impairment such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (b) has continued or can be expected to continue indefinitely; (c) is manifested before the individual attains age twenty-two (22); and (d) constitutes a substantial handicap to such individual's ability to function normally in society. A substantial functional handicap is a limitation in three (3) or more of the following areas of major life activity: self care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; or economic self-sufficiency. (1-7-94)

b. Eligible individuals may reside in adult foster care, residential care, semi-independent living, room and board, their own homes, or be homeless. (1-7-94)

c. Eligible individuals may be receiving habilitation, supportive assistance, respite, or other services. (1-7-94)

02. Service Description. TSC shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed

health, educational, vocational, residential, and social services using the least restrictive and most appropriate procedures and settings. TSC shall consist of the following core functions: (10-1-94)T

a. Individual Assessment and Service Planning. An Individual Support Plan (ISP) shall be developed in conjunction with the recipient and individuals the recipient wants to include, for example, his or her family, guardian, paraprofessional service coordinator, and service providers. (10-1-94)T

i. The ISP shall replace existing service plans, except when such plans are required by other rules, and be developed from a person centered planning process and include information obtained from evaluations (assessments), consumer interview, observation in community settings, and other pertinent information. (10-1-94)T

ii. The plan shall be directed at meeting the individual recipient's needs, primarily by building on, maintaining, and utilizing the recipient's identified strengths and abilities. Services proposed must: be the result of on-going planning; be built around the recipient's wants and needs; encourage the recipient to choose the locality in which he lives and works; be age appropriate; include, whenever possible, two or more options from which the recipient may choose; be aimed at maximizing community participation; be culturally appropriate; be designed to promote and utilize natural and informal community supports, including family, friends, and other non-paid citizens; and be designed with supports and services necessary to succeed in his chosen environment. (1-7-94)

b. The service coordinator is responsible for writing the plan, and submitting it to the Department for approval of Medicaid and state general fund eligibility. The service coordinator will be responsible for finding alternative funding/resources for services and supports not deemed eligible for Medicaid or state general fund reimbursement. (10-1-94)T

c. Implementation. The service coordinator shall arrange for services necessary to execute the ISP. (10-1-94)T

d. Monitoring. The service coordinator shall review, update and monitor the plan continuously to meet the recipient's changing needs. (10-1-94)T

i. Discuss the status of the ISP with the recipient in at least one face-to-face contact per month. (10-1-94)T

ii. Discuss all proposed changes and the options related to those changes with the recipient. (1-7-94)

iii. Maintain regular contact with all service providers active with the recipient, and participate in meetings to facilitate the coordination of services. (1-7-94)

iv. Discuss the recipient's (family or guardian if appropriate) satisfaction with the quantity and quality of services provided; (1-7-94)

v. Maintain documentation in the ISP of the service coordinator's (family member or guardian if appropriate) observations of the recipient engaged in ISP objective-oriented behavior; (10-1-94)T

vi. Maintain analysis of outcome data on ISP objectives; and (10-1-94)T

vii. Modify, change, terminate or add services based on these evaluations. (1-7-94)

e. Enablement. The service coordinator shall enable the recipient whenever possible. Enablement includes but is not limited to the following: (10-1-94)T

i. Providing information in ways that empower the recipient to make an informed decision; (1-7-94)

ii. Assuring that all placements in the service delivery system shall be to services which offer the individual the best available opportunity for personal development, provide an improved quality of life, and are within the least restrictive environment appropriate to the individual. (1-7-94)

iii. Ensure that all residential arrangements are community-based. Such arrangements may include, but are not limited to, the recipient's family's residence, or an independent living arrangement. (1-7-94)

iv. Ensure that providers comply with clients rights as specified in the Developmental Disabilities Act. (10-1-94)T

v. Assure that no one shall be denied TSC on the basis of the severity of physical or mental disability. (10-1-94)T

vi. If the placement or services which are recommended are not immediately available, continued attempts to try to access the service or placement for the recipient must be documented. (1-7-94)

vii. The service coordinator will foster the independence of the recipient (family or guardian if appropriate) by demonstrating to the individual how best to access service delivery systems. (10-1-94)T

03. Targeted Service Coordination Agency Qualifications. Targeted Service Coordination agencies must meet the following criteria: (10-1-94)T

a. Provide the anticipated non-Federal share of State general fund monies to the Medicaid account prior to billing for services; (10-1-94)T

a. Demonstrated ability to provide all the core elements listed in 03.09.119.02. of TSC to the target population; and (10-1-94)T

b. Provide consumers of the agency, the availability of a care coordinator on a twenty-four (24) hour basis to assist them in obtaining needed services. (10-1-94)T

c. May contract with individual service coordinators or case management agencies to provide TSC services. (10-1-94)T

d. Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency or their employees/contractors in any other agency that provides services to the developmentally disabled. (10-1-94)T

e. The individual or agency employees successfully complete the service coordination training specified by the Department; (10-1-94)T

f. The individual or agency follows the written procedures for service coordination authorized and adhered to by the Department; (10-1-94)T

g. Adheres to the Department's mission and value statements; and (10-1-94)T

h. Adheres to the Department's contract requirements, billing, and reimbursement procedures. (10-1-94)T

04. TSC Provider Staff Qualifications. All individual service coordinators must be employees or contractors of an organized provider agency that has a valid provider agreement/contract with the Department. The employing entity will supervise the individual service coordinators and assure that the following qualifications are met for each individual service coordinator: (10-1-94)T

a. Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.; Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners; and (10-1-94)T

b. Must have documentation of at least 18 months, at an average of 20 hours per week, of on-the-job experience providing service to the target population, or be working under the supervision of a fully qualified service coordinator; and (10-1-94)T

c. If possible, a criminal history check with finger printing shall be obtained; and (10-1-94)T

d. Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the recipient's needs are not met; provider agencies will supervise their service coordinators; and (10-1-94)T

e. Cannot be the service coordinator for any recipient for whom the service coordinator has individual responsibility for the provision of any other care or treatment; and (10-1-94)T

f. Cannot be responsible for the service coordination of more than thirty (30) individuals except under the following conditions: (10-1-94)T

i. The Bureaus of Medicaid Policy and Reimbursement and Developmental Disabilities may grant a waiver of the caseload limit when requested by the agency when the following criteria are met: (a) The availability of service coordinators is not sufficient to meet the needs of the service area; or (b) The recipient who has chosen a particular service coordinator who has reached their limit, has just cause to need that particular provider over other available providers; or (c) The individual service coordinator's caseload consists of twenty-five (25) percent or more maintenance level (two hours per month or less of service coordination services) consumers. (10-1-94)T

ii. The request for waiver must include: (a) The time period for which the waiver is requested; and (b) The alternative caseload limit requested; and (c) Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and welfare of any of the service coordinator's consumers. (10-1-94)T

iii. The Bureaus may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of TSC services provided. (10-1-94)T

g. Paraprofessionals may be used to assist in the implementation of the ISP. Paraprofessionals must meet the following qualifications: (10-1-94)T

i. Must be 18 years of age and have a high school diploma or the equivalent (G.E.D.); and (1-7-94)

ii. Must be able to read and write at a level commensurate with the general flow of paperwork and forms; and (1-7-94)

iii. Must complete a training program developed by the Division of Family and Community Services and be working under the supervision of a fully qualified service coordination; and (10-1-94)T

iv. If possible a criminal background check will be obtained. (10-1-94)T

05. Recipient's Choice. The choice of whether or not to receive TSC services will be the eligible recipient's. All recipients who choose TSC services will have free choice of authorized TSC providers, as well as, the providers of medical and other services under the Medicaid Program. (10-1-94)T

06. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as TSC services, however the actual provision of the services does not constitute TSC. Medicaid will only reimburse for core services (subsection 03.09.118.02.) provided to members of the eligible target group by qualified staff. (10-1-94)T

a. Payment for TSC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)T

b. Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MRs, or hospitals. (10-1-94)T

i. Medicaid will reimburse for TSC on the same date a recipient is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of the service delivery. (10-1-94)T

ii. TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility. (10-1-94)T

c. Reimbursement for TSC services shall be made on an fee for service basis for service provided as established by the Department. (10-1-94)T

d. The Department will not provide Medicaid reimbursement for ongoing TSC services delivered prior to the completion of assessments and ISP. (10-1-94)T

e. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and ISP. (10-1-94)T

f. Medicaid reimbursement will be provided only for the following TSC services: (10-1-94)T

i. Face-to-face contact between the service coordinator and the recipient, the recipient's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)T

ii. Telephone contact between the service coordinator and the recipient, the recipient's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)T

iii. Development, review, revision of the ISP. (10-1-94)T

g. The provider will provide the Department with access to all information required to review compliance with these rules. (1-7-94)

h. Failure to provide services for which reimbursement has been received or to comply with these rules and regulations will be cause for recoupment of payments for services, sanctions, or both. (1-7-94)

i. The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals. (10-1-94)T

j. The TSC agency must release all pertinent information to direct service providers. (10-1-94)T

07. Record Requirements. In addition to the development and maintenance of the ISP, the following documentation must be maintained by the provider: (10-1-94)T

a. Name of recipient; (1-7-94)

b. Name of provider agency and person providing the service; (1-7-94)

c. Date, time, and duration of service; (1-7-94)

d. Place of service delivery; (1-7-94)

e. Activity record describing the service(s) provided; (1-7-94)

f. Documented review of progress toward each service plan goal, and assessment of the recipient's need for TSC and other services as the recipient's needs change; (10-1-94)T

g. Documentation justifying the provision of crisis assistance to the recipient; and (1-7-94)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of TSC. (10-1-94)T

119. REHABILITATIVE SERVICES--RELATED SERVICES PROVIDED BY SCHOOL DISTRICTS. The Department will pay for rehabilitative related services pursuant to 42 CFR 440.130 (d), including medical or remedial services provided by school districts or other cooperative service agency (as defined in Idaho Code 33.317) which have entered into a provider agreement with the Department. Educational services, other than those "related services" found in 34 CFR 300.16, are the responsibility of the public schools and are not eligible for Medicaid payments. (10-22-93)

01. Recipient Eligibility. To be eligible for medical assistance reimbursement for covered services, a student shall: (10-22-93)

a. Be identified as having an educational disability pursuant to IDAPA 08.02.E.15,6.6.i.and ii. Department of Education standards for the education of disabled students; and (10-22-93)

b. Have an Individual Educational Program (IEP) plan which indicates the need for one or more medically necessary related services; and (10-22-93)

c. Be less than 22 years of age; and (10-22-93)

d. Be eligible for medicaid; and (10-22-93)

e. Be served by a school district that is an enrolled medical assistance provider pursuant to these rules. (10-22-93)

02. Evaluation and Diagnostic Services. (10-22-93)

a. Evaluations completed shall: (10-22-93)

i. Be recommended or referred by a physician; and (10-22-93)

ii. Be conducted by qualified professionals for the respective discipline as defined in Section 119.05.a.,119.05.b.,119.05.c.,119.05.d.; and (10-22-93)

iii. Be directed toward a diagnosis; and (10-22-93)

iv. Identify accurate, current and relevant student strengths, needs, and interests; and (10-22-93)

v. Recommend interventions to address each need. (10-22-93)

b. All initial evaluations must be completed within thirty (30) days of the date parental consent is obtained. Subsequent (e.g. annual) evaluations do not require new parent consent, but only written notice to the parent(s). If the initial evaluation is not completed within this time frame the student's record must contain client-based documentation justifying the delay. (10-22-93)

03. Payable Services. Schools may bill for the following related services provided to eligible students when provided under the recommendation of a physician: (10-22-93)

a. Speech evaluation, individual and group therapy; (10-22-93)

b. Audiology evaluation, individual and group therapy; (10-22-93)

c. Physical/occupational therapy evaluations, individual and group therapy; (10-22-93)

d. Psychological evaluations, individual and group therapy; (10-22-93)

e. Social history and evaluations; and (10-22-93)

f. Annual IEP plan development. (10-22-93)

04. Excluded Services. The following services are excluded from Medicaid payments to school based programs: (10-22-93)

a. Vocational services; and (10-22-93)

b. Educational services (other than related services) or education-based costs normally incurred to operate a school and provide an education; and (10-22-93)

c. Recreational services. (10-22-93)

05. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (10-22-93)

a. Speech evaluation and therapy: A person qualified to conduct speech/language evaluation and therapy who possesses a certificate of clinical competency in speech-language pathology or who will be eligible for certification within one (1) year of employment. Certification shall be from the American Speech Language and Hearing Association (ASHA). (10-22-93)

b. Audiology evaluation and therapy: A person qualified to conduct hearing evaluation and therapy, who possesses a certificate of clinical competency in audiology or who will be eligible for certification within one (1) year of employment. Certification shall be from the American Speech, Language and Hearing Association (ASHA). (10-22-93)

c. Physical/occupational therapy evaluation and therapy: (10-22-93)

i. Physical therapy: A person qualified to conduct physical therapy evaluations and therapy, who is registered to practice in Idaho. (10-22-93)

ii. Occupational therapy: A person qualified to conduct occupational therapy evaluations and therapy, who is certified by the American Occupational Therapy Certification Board and licensed to practice in Idaho. (10-22-93)

d. Psychological evaluation and therapy: A person who is qualified to provide psychological evaluation and therapy, who is licensed to practice (or is an approved service extender) in Idaho in one of the following disciplines: (10-22-93)

i. Psychiatrist, M.D.; or (10-22-93)

ii. Physician, M.D.; or (10-22-93)

iii. Psychologist, Ph.D., Ed.D, M.A./M.S.; or (10-22-93)

iv. Social Worker; or (10-22-93)

v. Registered Nurse. (10-22-93)

e. Social history and evaluation: A person who is licensed and qualified to provide social work in the State of Idaho; a registered nurse; psychologist; or M.D. (10-22-93)

06. Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by the school to provide related services (except psychotherapy) if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician. The portions of the treatment plan which can be delegated to the paraprofessional, as well as amount and scope of the supervision by the professional must be identified in the IEP. (10-22-93)

a. Paraprofessionals shall not conduct student evaluations or establish the IEP goals. (10-22-93)

b. The professional must have assessed the competence of the paraprofessional (aide) to perform assigned tasks. (10-22-93)

c. The paraprofessional, on a monthly basis, shall be given orientation and training on the program and procedures to be followed. (10-22-93)

d. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates. (10-22-93)

e. Any changes in the student's condition not consistent with planned progress or treatment goals necessitates a documented reevaluation by the professional before further treatment is carried out. (10-22-93)

f. If the paraprofessional works independently there shall be a review conducted by the appropriate professional at least once per month. This review will include the dated initials of the professional conducting the review. (10-22-93)

g. In addition to the above, if a paraprofessional is utilized to assist in the provision of actual physical therapy they may do so only when the following conditions are met: (10-22-93)

i. Student reevaluation must be performed and documented by the supervising PT every 5 visits or once a week if treatment is performed more than once per day. (10-22-93)

ii. The number of PTAs utilized in any practice or site, shall not exceed twice in number the full time equivalent licensed PTs. (10-22-93)

07. Payment for Services. Payment for school based related services must be in accordance with rates established by the Department. (10-22-93)

a. Payment will not be made for services if the state match portion is not in the individual school districts account. (10-22-93)

b. Providers of services must accept as payment in full the Department's payment for such services and must not bill Medicaid recipient's for any portion of any charges. (10-22-93)

c. Third party payment resources, not to include other school resources, such as private insurance, must be exhausted before the Department is billed for services. Proof of billing other third party payers is required. (10-22-93)

d. A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services provided under the school based program and codes. (10-22-93)

e. Payment for school based related services will not be provided to students who are inpatients in nursing homes or hospitals. (10-22-93)

f. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (10-22-93)

g. The provider will grant the Department access to all information required to review compliance with these rules. (10-22-93)

08. Record Requirements. In addition to the evaluations and maintenance of the Individual Educational Plan (IEP), the following documentation must be maintained by the provider: (10-22-93)

a. Name of student; and (10-22-93)

b. Name and title of the person providing the service; and (10-22-93)

c. Date, time, and duration of service; and (10-22-93)

d. Place of service; and (10-22-93)

e. Activity record describing the service provided and the student's response to the service; and (10-22-93)

f. Documented review of progress toward each service plan goal at least every 120 days; and (10-22-93)

g. Documentation of qualifications of providers. (10-22-93)

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES CENTERS. The Department will pay for rehabilitative services pursuant to 42 CFR 440.130(d), including medical or remedial services provided by facilities which have entered into a provider agreement with the Department and are licensed as developmental disabilities centers by the Division of Welfare, Bureau of Facility Standards. Educational services, other than those "related services" found in 34 CFR 300.13 and provided to all eligibles under the State Medical Plan, are the responsibility of the public schools and are not eligible for Medicaid payments. Covered "related services" include: audiology; psychotherapy services; physician services; developmental and occupational therapy; physical therapy; speech pathology and transportation necessary to obtain other covered services. (11-22-91)